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May 15, 1958, vol. 78

THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT: ITS IMPACT ON HOSPITAL ADMINISTRATION

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THE HOSPITAL INSURANCE and Diagnostic Services Act, Bill 320, which was passed by the House of Commons on April 10, 1957, provides for a contribution by the Federal Government of 50% of the cost, more or less, to any province which agrees to make insured hospital services, inpatient services and outpatient services, available, upon uniform terms and conditions, to all residents of the province so entitled under provincial law and without charge to the residents except a general charge by way of premium or other amount not related to a specific service and except authorized charges.

Hospitals covered under the Act do not include hospitals for tuberculosis or for the mentally ill, nor do they include nursing homes or any institution for custodial care. Drugs are excluded under outpatient services. Also excluded are capital expenditures and capital debts. Each province will administer its plan and each province has the right to decide how it will raise its share of the costs, whether it be by premium or taxation.

The present system has not met the needs of the Canadian people. Whether it was given a fair trial is a matter of debate, but that can only be of academic interest now. Bill 320 is a fact. We have a new order. We must meet the new order head on and overcome the problems which it will present. In so doing, we must resist to the full any attempts to "socialize" hospitalization on a national pattern, we must retain our autonomy, and we must accept the responsibility that goes with it at the provincial, at the municipal and at the individual hospital level. We must vigorously oppose any paternalistic attitude for the individual hospital by either the federal government or the provincial government and we must fight with every reasonable resource at our command any influence that would "nationalize" or "provincialize" our medical profession. There must be no companion to Bill 320 entitled "The Medical Practitioners' Services Act", and there will not be if the medical profession so sets its sights.

Bill 320 brings a new era in hospital administration. While the change will hardly be noticed in those provinces which have already had considerable experience in government-supported plans, it will pose problems in those provinces participating for the first time, quite different from those currently encountered.

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1. INCIDENCE OF ADMISSIONS

We may expect a greater incidence of admission of inpatients. That has been the experience under other government-supported programs. The factors would be: (1) patients hitherto reluctant to enter hospital because of the cost, unless absolutely essential, will now avail themselves of hospital care, and (2) until such time as effect is given to benefits under outpatient services, we might expect some tendency to enter hospital rather than undergo some inconvenience as an ambulatory patient.

Increased incidence of admissions will put a very great strain upon existing bed facilities and upon the load of the various laboratories.

One of the main problems will be an early understanding and continued prompting that the basic philosophy of the plan is to provide hospitalization for those in need of it for the absolute minimum length of stay, having due regard to good medical care.

The admission of a patient is effected upon the recommendation of his doctor, and so the responsibility of not admitting patients unless the need is essential must rest with the medical profession; as a technique to safeguard this principle there should be a committee of the medical staff charged with the review once monthly of all admissions of the previous month to see that there is no abuse. It is not an easy task for doctors to sit in judgment upon their confrères, but self-government by the medical staff implies acceptance of responsibility as well as of privileges, and the alternative can only be what the profession rightly fears, namely, direction by others.

The admission of one unnecessary case is a disservice to the program. One unnecessary admission multiplied a hundredfold in one hospital and many thousandfold across the country can only increase the cost of the plan to such an extent that there will not be enough money left to provide proper care where it is really needed. More important, the resulting unnecessary work load on hospital staffs would result in short ration of their time to patients who should have the best of care.

2. LENGTH OF STAY

Length of stay may well be a problem. A patient should stay in hospital not one day longer than is absolutely necessary. One part of the problem will be with that group of patients staying over 30 days because care in nursing homes, homes for the aged and facilities for custodial care is not covered under the Act; hence it will impose upon local authorities the responsibility to provide such facilities in order to have the maximum number of beds in general hospitals available for acute needs.

An even more important part of the problem is the danger of increasing the average length of stay of all patients. One day is a short time but an average increase of one day in the length of time

every patient stays in hospital would increase the cost of the plan by about 10%. Since discharge can only be accomplished upon the order of the doctor, it follows that, as with admissions, the responsibility lies primarily with the medical staff. Once again, the medical staff should have a committee, which may well be the same committee as the one on admissions, which will scrutinize fairly and fearlessly the length of stay of all patients discharged the previous month. The recommendations of this committee on admissions and discharges should be reported forthwith to the medical staff or to its executive, who would have power to act. The function of the administration would be to co-operate with the medical staff and to offer whatever help is necessary to expedite the work of the committee and the implementation of the recommendations of the medical staff. Of necessity, it would see that whatever reports are necessary, such as discharges by service, by doctor, by diagnosis and by length of stay, together with other pertinent information, would be made available to the committee.

3. FACILITIES

There will undoubtedly be need for more beds and ancillary services and this will mean demands for more staff. Unnecessary laboratory tests must be avoided as they are a waste of staff effort, of space and of money. In order that these needs for more facilities may be properly assessed, each hospital should have a representative standing committee to study the changing physical needs of the hospital and how they best can be met. Each province should have an authoritative body charged with the development and execution of a master plan of hospitals to ensure that proper and adequate facilities are located in the right places and that unnecessary duplication and overbuilding are avoided.

4. DRUGS

Drugs are provided under inpatient services but not under outpatient services. There should be a very active pharmacy committee of the medical staff of each hospital charged with the responsibility of seeing that drugs are dispensed with reason. It is a well-known fact that indiscriminate prescription of drugs can be both very costly and even wasteful.

5. CALIBRE OF HOSPITAL SERVICE

Eternal vigilance must be maintained to ensure that, no matter how great the demand for them may be, the calibre of hospital services will always be of the highest.

6. INTERN AND RESIDENCY TRAINING

One serious impact of the program will be felt in hospitals with intern training programs and more especially in those with residency training in which the public or ward patient has traditionally played a very large role. We do not know at the moment what shift there might be in the proportion of public patients to semi-private patients, or vice versa. Should there be a decrease in the number of public patients, and there may well be, then we must have a hard look at how best we can continue an adequate postgraduate training program for our young doctors. It would seem at the moment that we must do on a general scale what has already been done in some areas, and done for some time with considerable success, namely, the inclusion of both semi-private and private patients in the teaching program, having due regard for the wishes of the individual patient and attending doctor, and for the responsibility of the doctor both at law and to the postgraduate training program. The Act wisely makes no reference to this problem, and the inference is that the problem must be met and solved by the individual hospital. It might be added here that there is considerable merit in making a widespread change from the title "public" or "ward" patient to "staff" patient as more indicative of the fact that such patients are treated by a team of the medical staff.

7. PERSONNEL

Present shortage of personnel in many key areas of hospital work will be aggravated. Hospital administration will need to give particular attention to improve personnel policies so that they will be more in line with those of business and industry, notably with regard to the length of the work week. As a rule, present vacation and sick leave entitlement are satisfactory. The practice of gross salaries will be widespread and the institution of contributory pension and group life insurance plans will be common. Hospitals can hardly continue to stave off participation in the Unemployment Insurance scheme. Coverage of hospital employees by Workmen's Compensation will be the general rule. The trend will be towards more management-employee contractual working arrangements. These changes, which will add considerably to the payroll and hence to the per diem cost of hospitalization, will come about in orderly fashion because they are sound policies and not because someone has suddenly found a bottomless pit of new money.

There will be need to initiate new training programs and strengthen existing ones in order to attract and hold competent personnel in the many branches of hospital work—nurses, nursing assistants, dietitians and medical record librarians, to mention only a few.

8. CONTINUING SUPPORT OF THE PUBLIC

We have been assured by authoritative government officials that there is no intent to interfere with the independence and self-government of hos-

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pitals; that hospitals should continue to be governed by their governing boards as heretofore and that with this retention of the privilege of self-government must go the responsibility for the financing of capital expenditures, capital debt and interest thereon, prior debt and depreciation, for if government were to assume all financial responsibility for both operating and capital costs, then government would unquestionably own the hospitals. It follows that capital expenditures will continue to be the joint responsibility of the federal government (in so far as federal construction grants are allowed by law), the provincial government, the municipal government and the corporations and individuals of the community. Each hospital, through a job well done and through a good public relations program to extend and strengthen its importance in the community, must continually keep before the community the thought that even under changed conditions the citizens have a definite obligation to the hospital in this matter of capital needs, as well as the need to support research programs and other special projects. Capital financing of past and future debts is a most serious problem for hospitals and can only be solved by the combined effort of governments at all levels and the community. The need for even stronger, larger and more active women's auxiliaries and a greater army of volunteers is self-evident.

9. ACCOUNTING

There will be many changes in the functions of the accounting department. The present emphasis on billings, credit and collections may be considerably lessened and the worry of accounts receivable will be substantially reduced. On the other hand, a strong statistical department will be needed to take care of the increased volume of statistics and reports, and it is sincerely hoped that both will be kept to an absolute minimum.

Each hospital will have to pay increased attention to the details of its annual budget; budget systems and reports are bound to become more rigid in their application. Comparative cost studies will be essential both to hospitals and to health insurance authorities to support the claims of both parties. All this adds up to some increase in administrative costs.

CONCLUSION

The benefits under the Hospital Insurance and Diagnostic Services Act can be tremendous to the majority of our people, if wisely used; there is also no doubt that unless wisely used the costs of such benefits could soar to such astronomical proportions that they are bound to have some adverse effects on the municipal, provincial and even national economy.

UNIVERSAL HOSPITAL INSURANCE IN AUSTRALIA

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VOLUNTARY prepaid hospital insurance is not new. In fact, in one form or another it has been an adjunct to hospitalization over half a century in almost every country claiming an organized hospital system. However, with remarkably few exceptions hospital insurance has not become a potent force in hospital finance or as a means of bringing to all sections of a community ready access to skilled hospital care. A noteworthy exception is to be found in Australia.

The economic depression of the early thirties was a testing period for governments and for management. It was also a testing period for man's capacity for self-help, particularly in those countries boasting rising living standards. Organized voluntary prepaid hospital insurance in its recognizable form had its genesis in July 1932 in St. Paul, Minnesota and in Sydney, Australia.

In Canada and the U.S.A., Blue Cross in its contractual relationship with its members and with hospitals provides a means of insuring against the cost of hospitalization. Inflationary trends in the post-war years have resulted in the regular upward review of subscription rates. To Blue Cross there is the spectre of pricing itself out of existence as far as the "better risk" element of members is concerned and the triangular contract arrangement is not conducive to the economic management of hospitals.

This concept of "insurance against the cost" of hospitalization prevailed in Australia until the advent in 1946 of free hospital care for all. Non-profit hospital insurance plans had the wisdom to continue to honour their moral obligation to members by granting an equivalent cash benefit on the occasion of the hospitalization of a member or eligible dependent. The change to the life assurance concept of "insurance against the risk" was successfully accomplished.

Universal free hospital care was brought to an end after a thorough testing over six years. Prepaid hospital insurance was flourishing. The Australian Government in 1952 took the courageous step of registering as "approved organizations"

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